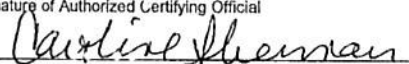


20039

FEDERAL FINANCIAL REPORT

(Follow form instructions)

1. Federal Agency and Organizational Element to Which Report is Submitted		2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment)		Page 1	of 1		
U.S. Department of Environmental Protection Agency		FS99290513-1		pages			
3. Recipient Organization (Name and complete address including Zip code)							
New York State Department of Health							
Empire State Plaza - Corning Tower							
Albany, New York 12237-0016							
4a. DUNS Number	4b. EIN	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment)	6. Report Type <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input checked="" type="checkbox"/> Final	7. Basis of Accounting <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accrual			
806781340	14-6013200	FS99290513					
8. Project/Grant Period From: (Month, Day, Year)		To: (Month, Day, Year)	9. Reporting Period End Date (Month, Day, Year)				
10/01/2012		09/30/2019	3/31/2017				
10. Transactions			Cumulative				
(Use lines a-c for single or multiple grant reporting)							
Federal Cash (To report multiple grants, also use FFR Attachment):							
a. Cash Receipts			\$0.00				
b. Cash Disbursements			\$0.00				
c. Cash on Hand (line a minus b)			\$0.00				
(Use lines d-o for single grant reporting)							
Federal Expenditures and Unobligated Balance:							
d. Total Federal funds authorized			\$55,485,000.00				
e. Federal share of expenditures			\$55,485,000.00				
f. Federal share of unliquidated obligations			\$0.00				
g. Total Federal share (sum of lines e and f)			\$55,485,000.00				
h. Unobligated balance of Federal funds (line d minus g)			\$0.00				
Recipient Share:							
i. Total recipient share required			\$16,645,500.00				
j. Recipient share of expenditures			\$16,645,500.00				
k. Remaining recipient share to be provided (line i minus j)			\$0.00				
Program Income:							
l. Total Federal program income earned			\$0.00				
m. Program income expended in accordance with the deduction alternative			\$0.00				
n. Program income expended in accordance with the addition alternative			\$0.00				
o. Unexpended program income (line l minus line m or line n)			\$0.00				
11. Indirect Expense	a. Type	b. Rate	c. Period From	Period To	d. Base	e. Amount Charged	f. Federal Share
g. Totals:						\$0.00	\$0.00
12. Remarks: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation:							
13. Certification: By signing this report, I certify that it is true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)							
a. Typed or Printed Name and Title of Authorized Certifying Official				c. Telephone (Area code, number and extension)			
Caroline Sherman, Director				(518) 474-1208			
Bureau of Account Management				d. Email address			
				caroline.sherman@health.ny.gov			
b. Signature of Authorized Certifying Official				e. Date Report Submitted (Month, Day, Year)			
				April 13, 2017			
				14. Agency use only:			

Standard Form 425

OMB Approval Number: 0348-0061

Expiration Date: 10/31/2011

Paperwork Burden Statement

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is